Supreme Court, U.S.
FILED
MAR 6 1992
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No. 91-1283

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

FRANK, GREENBERG, INDEPENDENT EXECUTOR
OF THE ESTATE OF
JOHN W. "JACK" McGANN
Petitioner,

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC
COMPANY, AND GENERAL AMERICAN LIFE
INSURANCE COMPANY,
Respondents.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Fifth Circuit

BRIEF FOR RESPONDENTS H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY IN OPPOSITION

MARK A. HUVARD
Counsel of Record

Harberg, Huvard, & Bisk
2100 Summit Tower
11 Greenway Plaza
Houston, Texas 77046
(713) 871-2424
Counsel for Respondents

Alpha Law Brief Co.* 6113 Aletha Lane* Houston, Texas 77081 (713)981-9000

QUESTIONS PRESENTED FOR REVIEW

1. Whether "any right" in ERISA § 510 means all rights, vested, non-vested, contingent or non-contingent at the time of contested employer actions?

2. Whether the uniform elimination of non-vested benefits, accomplished independently of employee discharge or harassment violates § 510 of ERISA?

3. Whether it is a defense to a plan participant's allegation of discrimination that a plan sponsor took action to save costs without taking actions that affected the employer-employee relationship?

4. Whether a self insured employer discriminates in violation of ERISA § 510 if the employer's medical plan contains a disease specific benefit cap?

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED FOR REVIEW i

TABLE OF AUTHORITIES iv

OPINIONS BELOW 2

JURISDICTION 2

STATUTORY PROVISION INVOLVED 2

COUNTERSTATEMENT OF THE CASE 3

A. NATURE OF CASE 3

B. FACTS 4

REASONS WHY THE WRIT SHOULD BE DENIED 6

I. THE FIFTH CIRCUIT'S HOLDING THAT UNIFORM ELIMINATION OF NON-VESTED BENEFITS ACCOMPLISHED INDEPENDENTLY OF EMPLOYEE DISCHARGE OR HARASSMENT IS CONSISTENT WITH OTHER CIRCUIT COURTS' APPLICATION OF ERISA § 510. 6

A. *MCGANN HAD NO "RIGHTS" TO WHICH HE WOULD HAVE BECOME ENTITLED UNDER THE H&H PLAN.* 7

1. *McGann did not have a vested benefit.* 7
2. *Only the Plan was affected, not McGann's employment.* 10

B. *THE FIFTH CIRCUIT'S INTERPRETATION OF "DISCRIMINATION" IS CONSISTENT WITH CONGRESS' INTENT THAT EMPLOYERS REMAIN FREE TO CREATE, MODIFY AND TERMINATE THE TERMS AND CONDITIONS OF EMPLOYEE BENEFITS PLANS WITHOUT GOVERNMENTAL INTERFERENCE.* 11

II. THE FIFTH CIRCUIT DID NOT CREATE A NEW BURDEN OF PROOF FOR PLAINTIFFS IN § 510 CASES. 14

III. THERE ARE NO PUBLIC POLICY REASONS FOR GRANTING THE PETITION 16

CONCLUSION 19

APPENDICES 1a

TABLE OF AUTHORITIES

Cases	Page
Aaronson v. Servus Rubber Div. of Chromalloy, 730 F.2d 12 (1st Cir.) *cert. denied* 469 U.S. 1017, (1984)	12
Alday v. Container Corp. of America, 906 F.2d 660 (11th Cir. 1990) *cert. denied* 111 S.Ct. 675 (1991)	10
Andersen v. John Morrell & Co. 789 F.2d 244 (3rd Cir. 1986)	8
Anderson v. Alpha Portland Industries, Inc., 647 F.Supp. 1109 (E.D. Mo. 1986), Affirmed, 836 F.2d 1512 (8th Cir. 1988)	8
Clark v. Resisto Flex Co., a Division of UniDynamics Corp., 854 F.2d 762, 770 (5th Cir. 1988)	15
Deeming v. American Standard, Inc., 905 F.2d 1124, (7th Cir. 1990)	10, 13
Dister v. Continental Group, Inc., 859 F.2d 1108 (2nd Cir. 1988)	16
Fitzgerald v. Codex Corp., 882 F.2d 586 (1st Cir. 1989)	11
Folz v. Marriott Corp., 594 F.Supp. 1007 (W.D. Mo. 1984)	11

Gavalik v. Continental Can Co., 812 F.2d 834 (3rd Cir. 1987) 12, 16

Gutting v. Falstaff Brewing Corp., 541 F.Supp. 345 (E.D. MO. 1982) 9

Hamilton v. The Travelers Insurance Company, 587 F.Supp. 521 (D. MO., 1984) 9

Hamilton v. The Travelers Insurance Company, 752 F.2d 1350 (8th Cir. 1985) 9

Ingersoll-Rand Co. v. McLendon, 498 U.S.____111 S.Ct. 478, 112 L.Ed.2d 474 (1990) 10

Kimbro v. Atlantic Richfield Co., 889 F.2d 869, 881 (9th Cir. 1989)*Cert denied* 15

Kross v. Western Electric Co., 701 F.2d 1238 (7th Cir. 1983) 11

McGann v. H&H Music Company, et al, 946 F.2d 401, (5th Cir. 1991) 7, 12, 15, 16

Moore v. Metropolitan Life Insurance Company, 856 F.2d 488, (2nd Cir. 1988) 7, 8, 12, 17, 18

Moore v. Reynolds Metals Co. Retirement Program, 740 F.2d 454 (6th Cir. 1984) 12, 14

Musto v. American General Corp., 861 F.2d 897(6th Cir)(1988) 12, 14, 17, 18

Owens v. Storehouse, Inc., 773 F.Supp. 416, (N.D. Ga. 1991) 13

Philips v. Amoco Oil Company, 799 F.2d 1464 (5th Cir. 1986) *cert. denied* 481, U.S. 1016 (1987) 10

Shaw v. Delta Airlines, Inc., 463 U.S. 85, (1983) 13

Tackitt v. Prudential Insurance Company of America, 758 F.2d 1572 (11th cir. 1985) 9

Viggiano v. Shenango China Division of Anchor Hocking, 750 F.2d 276 (3rd Cir. 1984) 13

Vogel v. Independence Federal Savings Bank, 728 F.Supp. 1210 (D.Md. 1990) 11

West v. Butler, 621 F.2d 240, (6th Cir. 1980) 11

Statutes and Regulations **Page**

28 U.S.C. § 2101(c) 2

29 U.S.C. § 1140 7

29 U.S.C. § 1002(1) 7

29 U.S.C. § 1341-1348 (1982) 9

Employee Retirement Income Security Act of 1974 ("ERISA"), Publication Number 93-406, 88 Stat. 832 (29 U.S.C. § 1140) ("Section 510") 2, 7, 10, 18

Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq* 3

Welfare and Pension Plans Disclosure Act (29 U.S.C.A. § 301 *et seq.*) 2

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FRANK GREENBERG, Independent Executor of the Estate of John W. "Jack" McGann,

Petitioner,

v.

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY,

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**ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

BRIEF FOR RESPONDENTS H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY IN OPPOSITION

Respondents submit this Brief to demonstrate that a Writ of Certiorari should be denied.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 946 F.2d 401. The opinion of the District Court is reported at 742 F.Supp. 392.

JURISDICTION

The judgment of the Court of Appeals was entered on November 4, 1991. The Petition for a Writ of Certiorari was filed on February 3, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. § 2101(c).

STATUTORY PROVISION INVOLVED

This case involves § 510 of the Employee Retirement Income Security Act of 1974 ("ERISA"), Publication Number 93-406, 88 Stat. 832 (29 U.S.C. § 1140) ("Section 510") which provides in pertinent part as follows:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, this subchapter, Section 1201 of this title, or the Welfare and Pension Plans Disclosure Act (29 U.S.C.A. § 301 *et seq.*), or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan, this subchapter, or the Welfare and Pension Plans Disclosure Act.... The provisions of Section 1132 of this title shall be applicable in the enforcement of this section.

COUNTERSTATEMENT OF THE CASE

A. NATURE OF CASE

On August 2, 1989, Plaintiff, John McGann ("McGann") filed his First Amended Complaint against Defendants H & H Music Company ("H&H"), Brook Mays Music Company ("Brook Mays") and General American Life Insurance Company ("General American") for alleged violation of his rights under § 510 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA").[1] McGann alleged that Defendants discriminated against him because he exercised rights to which he was entitled under the provisions of H&H's Employee Benefit Plan. Specifically, McGann asserted that H&H, Brook Mays and General American interfered with the attainment of rights to which he would have become entitled under the plan by wrongfully changing the employee benefits coverage provided to McGann. (Resp. App. 13a-15a).[2]

All Defendants moved to dismiss the complaint under Rule 12, Federal Rules of Civil Procedure. These motions which the District Court did not consider separately were re-urged in subsequently filed Motions for Summary Judgment. For purposes of the Motions for Summary Judgment, all Defendants conceded the factual allegations contained in Plaintiff's First Amended Complaint. The District Court ruled that H&H had complied with ERISA; that it had the right to make changes in its group medical plan; and that it did not act in a discriminating manner in changing the terms of the plan.

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[1]H&H Music Company and Brook Mays Music Company will be collectively referred to as "H&H" unless otherwise noted.

[2]Resp. App. cites refer to Respondents' Appendice.

The Final Judgment dismissing the case was entered on June 28, 1990. On appeal, a panel of the Fifth Circuit affirmed the judgment holding that McGann had not adduced evidence of any right to receive future medical benefits under the H&H Medical Benefits Plan, and therefore H&H did not unlawfully discriminate against McGann within the meaning of § 510 of ERISA.

B. FACTS

McGann had been an employee of H&H since 1982. During his employment, McGann had been covered by H&H's group medical care plan, which was administered by Brook Mays. Pursuant to the plan in effect from August 1, 1987 to July 31, 1988, all listed coverages were fully insured. The life and accidental death and dismem- berment insurance coverages were funded on a conventional premium basis. The medical coverage was funded by a minimum premium arrangement. General American received minimum premiums to administer and pay claims and to provide excess risk insurance for individual claims over $25,000. H&H was responsible for funding benefits covered by the plan up to the first $25,000. per Claimant. (Resp. App. 2a-7a).

In December, 1987, McGann was diagnosed as having Acquired Immune Deficiency Syndrome ("AIDS"). He alleged that in March, 1988 he met with officials of H&H and discussed his illness. (Resp. App. 23a).

By letter dated July 28, 1988, Brook Mays announced that the medical care plan covering H&H's employees was terminated effective August 1, 1988 and that a new group medical/hospitalization plan would be put into place. (Resp. App. 26a-28a) The medical coverage changed from fully insured to self-insured. Pursuant to an Administrative Services Agreement, General American received

administrative services fees only to administer and pay claims. (Resp. App. 5a) In addition, General American received premiums for excess risk coverage to provide for individual claims over $25,000.00 and aggregate indemnification to limit the overall claim liability of the plan. Since the new plan was self-insured, no policy regarding medical benefits was issued to Brook Mays by General American. Rather the Summary Plan Description ("SPD") provided to employees contained the medical benefits offered by H&H. Benefits payable for AIDS related claims under the new plan were a lifetime maximum of $5,000.00. (Resp. App. 32a).

There were several additional major differences between the prior year's plan and the one that was instituted on August 1, 1988. Among these differences were the following:

1. The individual calendar year deductible was increased from $200.00 to $300.00. The family deductible was increased from $600.00 to $900.00;

2. The individual "stop loss" was increased from $4,000.00 in benefits to $10,000.00 in covered expenses;

3. All treatment for chemical dependency (drug abuse and alcoholism) was excluded from the plan;

4. A PPO (Preferred Provider Organization) network was added to the plan. Covered expenses in a PPO doctor's office were paid at one hundred percent (100%), subject to a Ten Dollar encounter fee instead of eighty

percent (80%), subject to the calendar year deductible. All other PPO doctor and hospital charges were paid at ninety percent (90%) instead of eighty percent (80%). Covered expenses for non-PPO providers remained unchanged.

5. Employee contributions were required to be increased by Two and 75/100 Dollars per payday for individual coverage and Seventeen and 50/100 Dollars per payday for family coverage.

The H&H Medical Benefits Plan was changed with the intent of preserving its financial integrity while at the same time allowing it to continue to provide health coverage for the employees of H&H. (Resp. App. 7a)

McGann received all of the benefits to which he was entitled under the H&H Medical Benefits Plan and did not complain of discriminatory treatment in the attainment of those benefits.

REASONS WHY THE WRIT SHOULD BE DENIED

COUNTERPOINT I

I. THE FIFTH CIRCUIT'S HOLDING THAT UNIFORM ELIMINATION OF NON-VESTED BENEFITS ACCOMPLISHED INDEPENDENTLY OF EMPLOYEE DISCHARGE OR HARASSMENT IS CONSISTENT WITH OTHER CIRCUIT COURTS' APPLICATION OF ERISA § 510.

A. *MCGANN HAD NO "RIGHTS" TO WHICH*

HE WOULD HAVE BECOME ENTITLED UNDER THE H&H PLAN.

McGann sought to create a right to permanent medical benefits by requiring that his medical benefits be afforded vested status. Without such a "right" to permanent medical benefits McGann did not have a claim of discrimination under § 510. *McGann* 946 F.2d 401, 405 (5th Cir. 1991). The Fifth Circuit did not, as is erroneously asserted by Petitioner, narrowly interpret § 510 to mean that it was only unlawful to interfere with an employee's right to recover "permanent" benefits under an ERISA plan. Rather the court found that McGann did not have a vested benefit, and thus he did not have a right to unchanged permanent medical benefits. Applying McGann's construction of § 510 would create a permanent obligation on the part of H&H where statutorily and contractually no obligation existed. McGann assumed he had a "right" to unchanged permanent medical benefits. This is wrong as a matter of law.

1. ***McGann did not have a vested benefit.***

The H&H welfare plan was not subject to the vesting requirements of 29 U.S.C. § 1140 and thus could be terminated at will. Termination of the plan necessarily terminated any rights McGann had to its benefits, since the plan would no longer be in existence to provide those benefits.

The H&H plan was a welfare benefit plan under § 3(1) of ERISA 29 U.S.C. § 1002(1). It provided life, accidental death and dismemberment and medical care benefits and was exempted from ERISA's vesting requirements. *Moore v. Metropolitan Life Insurance Company*, 856 F.2d 488, (2nd Cir. 1988). The *Moore* court stated the rationale for exempting welfare benefit plans from ERISA's vesting requirments:

> ERISA regulates pension plans far more extensively than welfare plans. For example, welfare plans are expressly exempted from the acts detailed minium participation, vesting and benefit accrual requirements and are not subject to ERISA's minimum funding requirements. As explained by committees of both the House and Senate, the term "accrued benefit refers to pension or retirement benefits and is not intended to apply to certain ancillary benefits, such as medical insurance or life insurance, which are sometimes provided for employees in conjunction with a pension plan, and are sometimes provided separately. To require the vesting of these ancillary benefits would seriously complicate the administration and increase the cost of plans whose primary function is to provide retirement income.

Moore, 856 F.2d at 491, citing H.R.Rep. No. 93-807, 93D Cong., 2d. Sess., reprinted in the 1974 U.S. Code Congressional and Administrative News 4639, 4670, 4726; S.Rep. No. 93-383, 93D Cong., 2d Sess., reprinted in 1974 U.S. Code Congressional and Administrative News 4639, 4890, 4935.

The Court in *Moore* also said that Congress intended the plan documents and the SPD to govern exclusively an employer's obligation under ERISA plans. *Id.* at 492. *See also, Andersen v. John Morrell & Co.* 789 F.2d 244 (3rd Cir. 1986); *Anderson v. Alpha Portland Industries, Inc.*, 647 F.Supp. 1109 (E.D. Mo. 1986), Affirmed, 836 F.2d 1512 (8th Cir. 1988).

The Eighth Circuit addressed the issue of termination

of welfare benefit plans in *Hamilton v. The Travelers Insurance Company*, 752 F.2d 1350 (8th Cir. 1985). In *Hamilton*, an employee brought a declaratory judgment action to establish that the defendant employer and health insurer were required to provide insurance benefits for expenses incurred in treating his son's eye injury after his son became nineteen (19) years of age and after the insurance policy was terminated. Causes of action were alleged for breach of contract and for violation of ERISA. The Court stated that:

> The Summary Plan Description Booklet provides that Altorfer, as the plan's administrator, may terminate the plan in whole or in part at any time, subject to the applicable provisions of the welfare insurance policies. Clearly, Altorfer was under no contractual obligation to refrain from terminating the plan. Finally, we agree with the District Court's conclusion that ERISA does not create liability on the part of the employer who changes the kind of health plan provided to employees where no contract prohibits or prevents such change.

Id. at 351. The Court then concluded that the employer and insurance company were entitled to judgment as a matter of law since ERISA did not prohibit them from terminating this medical benefits plan. *See also, Hamilton v. The Travelers Insurance Company*, 587 F.Supp. 521 (D. Missouri, 1984) (Citing *Gutting v. Falstaff Brewing Corp.*, 541 F.Supp. 345 (E.D. Missouri 1982), *See also* 29 U.S.C. § 1341-1348 (1982).

Similarly, in *Tackitt v. Prudential Insurance Company of America*, 758 F.2d 1572 (11th Cir. 1985), the court held

that the defendants could reduce plan benefits based upon the unambiguous language of the plan documents. *See also Alday v. Container Corp. of America*, 906 F.2d 660 (11th Cir. 1990) *cert. denied* 111 S.Ct. 675 (1991), *Philips v. Amoco Oil Company*, 799 F.2d 1464 (5th Cir. 1986) *cert. denied* 481, U.S. 1016 (1987). *No other Circuit Court has held that medical benefits vest.*

The Fifth Circuit's ruling is consistent with the legislative history of ERISA, as well as decisions rendered in other circuits regarding vesting of medical benefits.

2. *Only the Plan was affected, not McGann's employment.*

Many courts have expressly held that § 510 requires that the individual's employment relationship, not merely the plan, be affected by the alleged discrimination. *Deeming v. American Standard, Inc.*, 905 F.2d 1124, (7th Cir. 1990).

The type of discrimination that Congress intended to prohibit under § 510 is a claim for termination of employment "motivated by an employer's desire to prevent a pension from vesting." *Ingersoll-Rand Co. v. McLendon*, 498 U.S. _____ 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). ERISA's legislative history confirms that Congress enacted § 510 in order to prevent unscrupulous employers from discharging or otherwise interfering with the employment status of employees whose pension rights were about to vest:

> These provisions were added by the committee in the face of evidence that in some plans a workers' pension rights or the expectations of those rights were interfered with by the use of economic sanctions or violent reprisals.

S.Rep. No. 93-127, 93d Cong., 2d Sess., *reprinted at* (1974) U.S. Code Cong. & Admin. News, pp. 4838, 4872, *quoted in West v. Butler*, 621 F.2d 240, 245 (6th Cir. 1980).

McGann cites numerous cases in support of his proposition that H&H discriminated against him, and in support of the charge that the Fifth Circuit is in conflict with other circuits. However, in each of these cases the employment relationship and not the plan was affected by employer action. Those cases correctly hold that termination of employment is a violation of § 510, if the purpose of the termination was to interfere with an employee's continued coverage under an insurance plan or for the purpose of interfering with the attainment of a right under either a pension or a welfare benefit plan. *See, Fitzgerald v. Codex Corp.*, 882 F.2d 586 (1st Cir. 1989); *Kross v. Western Electric Co.*, 701 F.2d 1238 (7th Cir. 1983); *Folz v. Marriott Corp.*, 594 F.Supp. 1007 (W.D. Mo. 1984); *Vogel v. Independence Federal Savings Bank*, 728 F.Supp. 1210 (D.Md. 1990). Yet, McGann's employment was never terminated. Since only the plan was affected and not McGann's employment relationship, the Fifth Circuit correctly restricted the application of ERISA § 510.

B. THE FIFTH CIRCUIT'S INTERPRETATION OF "DISCRIMINATION" IS CONSISTENT WITH CONGRESS' INTENT THAT EMPLOYERS REMAIN FREE TO CREATE, MODIFY AND TERMINATE THE TERMS AND CONDITIONS OF EMPLOYEE BENEFITS PLANS WITHOUT GOVERNMENTAL INTERFERENCE.

McGann cites no case to support the proposition that Congress explicitly limited an employer's discretion to alter the terms of welfare benefit plans by enacting ERISA § 510.

> McGann effectively contends that § 510 was intended to prohibit any discrimination in the alteration of an employee benefits plan that results in an identifiable employee or group of employees being treated differently from other employees.

McGann, 946 F.2d at 406. This position is wrong as a matter of law and it is not consistent with the holdings from other circuits.

First, under ERISA, discrimination can only be proven by showing: (1) prohibited employer conduct, (2) taken for the purpose of interfering, (3) with the attainment of any right to which the employee may become entitled. *Gavalik v. Continental Can Co.*, 812 F.2d 834 (3rd Cir. 1987). McGann presented no evidence to suggest that the action taken by H&H was prohibited. Employer conduct, so long as it is not prohibited, may lawfully interfere with an employee's rights. Many courts have thus recognized an employer's lawful reduction of employee benefits. *Moore v. Reynolds Metals Co. Retirement Program*, 740 F.2d 454 (6th Cir. 1984); *Musto v. American General Corp.*, 861 F.2d 897 (6th Cir. 1988); *Moore v. Metropolitan Life Insurance Company, supra.* The reduction of benefits does not constitute discrimination.

The First Circuit rejected a contention similar to McGann's in *Aaronson v. Servus Rubber Div. of Chromalloy*, 730 F.2d 12 (1st Cir.) *cert. denied* 469 U.S. 1017, (1984). The Court in *Aaronson* stated in part:

> § 510 relates to discriminatory conduct directed against individuals, not to actions involving the plan in general. The problem is with the word 'discriminate.' An overly lit-

> eral interpretation of this Section would make illegal any partial termination, since such terminations obviously interfere with the attainment of benefits by the terminated group, and indeed, are expressly intended so to interfere.

See also Owens v. Storehouse, Inc., 773 F.Supp. 416, 418 (N.D. Ga. 1991) (relying on *Deeming* in rejecting a claim that employer violated § 510 by reducing AIDS benefits from One Million to $25,000.00 under employee health plan on the ground that § 510 was designed to protect the employment relationship, not the integrity of specific plans.)

ERISA only concerns the elements of a plan and its administration after it has been established. It does not affect the creation of a program. ERISA does not mandate that employers provide any particular benefits, and does not itself proscribe discrimination in the provision of employee benefits. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, (1983). ERISA does not require an employer to establish a hospitalization plan, nor continue it indefinitely. *Viggiano v. Shenango China Division of Anchor Hocking*, 750 F.2d 276 (3rd Cir. 1984). Additionally, once an employer makes a determination to provide a welfare benefit plan:

> Neither Congress nor the Courts are involved in either the decision to establish a plan or in the decision concerning which benefits a plan should provide. In particular, Courts have no authority to decide which benefits employers must confer upon their employees; these are decisions which are more appropriately influenced by forces in the market place and, when appropriate, by Federal Legislation.

Moore v. Reynolds Metals Co. Retirement Program, 740 F.2d at 456.

Moreover, a company in its role as employer can change the design of its welfare benefit plan for a purpose other than that of benefiting the plan's participants and their beneficiaries.[3] *Musto v. American General Corp.*, 861 F.2d at 911. The H&H plan terminated on July 31, 1988. Contractually, any benefits to which McGann was entitled terminated on that date as well. Under the H&H plan, the only rights McGann had were those set out in the SPD; he could not obtain rights greater than those which were contractually owed through the plan documents. Finally, H&H's new self-insured welfare benefit plan could place a sublimit on its lifetime benefits payable on any particular disease. The Fifth Circuit's reading of the statute clearly comports with case law, public policy and Congressional intent on these issues.

COUNTERPOINT II

II. THE FIFTH CIRCUIT DID NOT CREATE A NEW BURDEN OF PROOF FOR PLAINTIFFS IN § 510 CASES.

The Fifth Circuit did not elevate cost savings to the status of an absolute defense. The court recognized that McGann offered no evidence to substantiate his claim of discrimination beyond the defendants' admitted sole purpose of saving money. Defendants' admission was not sufficient

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[3]The Court in *Musto v. American General Corp.*, cited the testimony of Mr. Donald S. Grubbs, Jr., a consulting actuary and attorney who had been retained to advise the Senate Subcommittee that developed ERISA. According to the Court, Grubbs testified that Congress clearly did not attempt to preclude the right of employers to reduce benefits under welfare plans.

evidence of their discriminatory intent absent evidence of additional prohibited conduct affecting the employer-employee relationship.

McGann did not have a right to permanent unchanged medical benefits either statutorily or contractually. The lawful termination of H&H's plan and the subsequent cap on benefits was not sufficient evidence of the Defendants' discriminatory intent. The court noted,

> McGann appears to contend that the reduction in AIDS benefits alone supports an inference to retaliate against him or to interfere with his future exercise of rights under the plan... under McGann's theory, any reduction in employee benefits would be impermissibly discriminatory if motivated by desire to avoid the anticipated cost of continuing to provide coverage for a particular beneficiary.

McGann, 946 F.2d at 405. Cost savings can support a finding of unlawful motivation, but there must be evidence of additional prohibited employer conduct to support a § 510 claim, *e.g.*, termination of employment. This additional prohibited conduct is absent in this case.

McGann failed in meeting his burden of adducing some evidence that the Defendants intended to discriminate against McGann and McGann only for filing AIDS related claims. The Fifth Circuit did not create a new burden of proof but rather held McGann to the standard required by numerous decisions. *Kimbro v. Atlantic Richfield Co.*, 889 F.2d 869, 881 (9th Cir. 1989) (employee must prove employer's specific intent to retaliate for employee's exercise of rights under plan) *cert. denied*, _____ U.S. _____, 111 S.Ct. 53, 112 L.Ed. 2d 28 (1990); *Clark v. Resisto Flex Co.*,

a Division of UniDynamics Corp., 854 F.2d 762, 770 (5th Cir. 1988), *Dister v. Continental Group, Inc.*, 859 F.2d 1108 (2nd Cir. 1988); *Gavalik v. Continental Can Co.*, *supra*.

COUNTERPOINT III

III. THERE ARE NO PUBLIC POLICY REASONS FOR GRANTING THE PETITION

The Fifth Circuit's decision rejecting this § 510 claim is consistent with the principle that Congress did not intend that ERISA circumscribe employers' control over the content of benefits plans they offer to their employees.

> If a Federal Court could prevent an employer from reducing an employee's coverage limits for AIDS treatments, once that employee contracted AIDS, the boundaries of judicial involvement in the creation, alteration or termination of ERISA plans would be sorely tested.

McGann, 946 F.2d at 407-408.

Congress knew that every time an employer reduced the medical benefits offered through that employer's welfare benefit plan, the employer intended to deprive its employees of the affected benefits. To accept McGann's rationale is to accept the proposition that medical benefits, once in place, can never be reduced without violating § 510 of ERISA. Congress never intended this application, and McGann was never entitled to health benefits whose terms would never change.

Medical plans, and the basis upon which they are

offered and paid for, are different from pension plans. Congress recognized this fact in the statutory scheme defining the difference between pension plans and welfare plans containing medical benefits.

> With regard to an employer's right to change medical plans, Congress evidenced its recognition of the need for flexibility in rejecting the automatic vesting of welfare plans. Automatic vesting was rejected because the costs of such plans are subject to fluctuating and unpredictable variables. Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in the cost of treatment independent of inflation. These unstable variables prevent accurate prediction of future needs and costs. While these Plaintiffs would be helped by a decision in their favor, such a ruling would not only fly in the face of ERISA's plain language but would also decrease protection for future employees and retirees.

Moore v. Metropolitan Life Insurance Company, 856 F.2d at 492. An employer should be able to consider increased costs of future treatments and future needs in tailoring its medical plans. H&H was statutorily entitled to consider the future anticipated cost to its welfare benefit plan of AIDS treatment. Similarly, H&H was entitled to consider the cost to its welfare benefit plan of any other coverage, such as for alcohol and drug abuse treatment.

The court in *Musto v. American General Corp.*, stated

the rationale for allowing employers the right to amend their welfare benefit plans when it stated the following:

> National Life had no fiduciary duty to establish any medical insurance plan, much less one that could never be amended without the approval of those to whom it applied. It is hard to see how the company's express reservation of a right to amend the plan can be said to constitute 'over reaching' when a prudent employer, mindful of the possibility that medical costs might skyrocket, could well have decided, if given the slightest reason to suppose that future amendments to the medical insurance coverage could be invalidated under ERISA, not to provide such coverage at all, or to impose the most stringent limits on any coverage provided.

Musto, 861 F.2d at 912.

Public policy requires that employers be given wide latitude in designing their welfare benefits plans as the *Moore* and *Musto* Courts noted. McGann's public policy argument flies in the face of common sense. Employers provide jobs; they are not yet required to provide health insurance. To the extent employers provide medical benefits, their plans must be administered fairly. However, employers should remain free to offer whatever benefits they choose, or as the *Musto* Court explained, employers may offer no coverage at all. Given the choice between a system of no coverage or a system of employer chosen benefit packages, public policy mandates the latter choice. McGann's public policy argument would eliminate that choice and, in all probability, medical insurance coverage for a large number of Americans. The Fifth Circuit's decision recognized this reality and the consequences of a different decision.

would eliminate that choice and, in all probability, medical insurance coverage for a large number of Americans. The Fifth Circuit's decision recognized this reality and the consequences of a different decision.

CONCLUSION

The Fifth Circuit's decision in this case and its reading of § 510 of ERISA is consistent with Congressional intent, the public policy behind that intent and other circuits' decisions and therefore respondents respectfully submit that this court deny petitioner's request for writ of certiorari.

Dated: Houston, Texas
February 17, 1992

Respectfully submitted,

HARBERG, HUVARD & BISK

By: _____

MARK A. HUVARD
2100 Summit Tower
11 Greenway Plaza
Houston, Texas 77046
(713) 871-2424
Counsel for Respondents
H&H Music Company and
Brook Mays Music Company

INDEX TO APPENDICES

Page

Affidavit of William C. Everitt, Sr., Chairman of the Board of H&H Music Company and Brook Mays Music Company 2a

Plaintiff's First Amended Complaint 8a

Affidavit of John McGann 22a

Letter to H&H Music Company Employees dated July 28, 1988 ..... 25a

Relevant excerpts from Brook Mays/H&H Summary Plan Description Booklet for Plan in effect from August 1, 1987through July 31, 1988 ..... 27a

Relevant excerpts from Brook Mays/H&H Summary Plan Description Booklet forPlan in effect from August 1, 1988 through July 31, 1989 ..... 30a

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN MCGANN,
PLAINTIFF

vs.
H&H MUSIC CO., BROOK MAYS MUSIC CO., AND GENERAL AMERICAN LIFE INSURANCE COMPANY
DEFENDANTS

CIVIL ACTION
NO. 89-1995

AFFIDAVIT

BEFORE ME, the undersigned authority, on this day personally appeared William C. Everitt, Sr., who being by me duly sworn upon his oath, deposed and stated the following:

"My name is William C. Everitt, Sr., and I am over the age of eighteen (18) years and am competent to make this Affidavit. I am Chairman of the Board of H&H Music Company and Brook Mays Music Company, two (2) of the Defendants in the above styled and numbered cause. Additionally, I am familiar with all of the allegations contained in the Plaintiff's First Amended Complaint, and I have personal knowledge of the facts stated herein.

At all times material to the allegations contained in the Plaintiff's First Amended Complaint, the employees of H&H Music Company were entitled to participate in Brook Mays Music Company's welfare plan providing life, accidental death, and dismemberment and medical care benefits. The plan's sponsor and Administrator was Brook Mays Music Company. Throughout the years, the benefits offered to the employees of both Brook Mays Music

Company and H&H Music Company have changed substantially.

Effective September 1, 1983, Brook Mays Music Company was issued Policy Number MCP-5353 (reissued) by General American Life Insurance Company. That policy was amended from time to time as is evident from Exhibit "A" to the Appendix attached hereto. After the initial effective date of the policy, September 1, 1983, each policy year began on August 1 of each successive year. In December, 1987, when Plaintiff Jack McGann was diagnosed as having AIDS, this was the health policy in effect. All of the coverages under this policy were fully insured. The life and accidental death and dismemberment insurance coverages were funded by a conventional premium basis. The medical coverage was funded by a minimum premium arrangement. General American received minimum premiums to administer and pay medical claims and to provide excess risk insurance for individual claims over Twenty-Five Thousand and no/100 Dollars ($25,000.00) and aggregate insurance to limit the overall claim liability of the plan.

There were a number of ways to fund the insurance coverages obtained from time to time by Brook Mays Music Company. Funding methods do not necessarily affect whether or not a welfare plan is fully insured or self insured. Under a traditional, conventional funding method, Brook Mays Music Company would have been charged a premium based upon the insurance carrier bearing one hundred percent (100%) of the risk of all claims. General American Insurance Company would calculate Brook Mays Music Company's premium based upon actual experience and General American's underwriting guidelines. In the event that claims were not overly excessive in any plan year, the premiums paid might be in excess of the amount actually required to fully compensate General American. In this instance, the surplus premium paid would be returned to

Brook Mays Music Company in the form of a dividend.

Brook Mays Music Company went to a minimum premium funding method for the plan year beginning August 1, 1984. This method of funding had no impact on the Company's welfare plan which remained fully insured, but rather only affected the amount of premium payable on an up-front basis by Brook Mays Music Company to General American Insurance Company. For the plan year beginning August 1, 1987, Brook Mays Music Company was responsible for paying individual claims up to Twenty-Five Thousand and no/100 Dollars ($25,000.00). General American Insurance Company provided excess risk insurance, which covered claims above Twenty-Five Thousand and no/100 Dollars ($25,000.00) and aggregate insurance to limit the total number of dollars that would need to be paid by Brook Mays Music Company under this plan. For the plan year beginning August 1, 1987, through July 31, 1988, the minimum premium per employee per month for medical coverage only was Thirty-Six and 49/100 Dollars ($36.49).

During the plan years prior to August 1, 1988, the losses for the plan had mounted steadily. In the immediate prior year, for every dollar that was received in premium, almost One and 50/100 Dollars ($1.50) was spent in benefit payment payments. Brook Mays Music Company was faced with either dropping the plan completely or redesigning the benefits in order to get costs back under control in order that all employees could still receive benefits under this welfare plan. Therefore, the old welfare plan was terminated, and beginning August 1, 1988, a new plan was instituted. Under the new plan, the life, accidental death and dismemberment coverages remained fully insured and continued to be funded by conventional premium basis. The medical coverage changed from fully insured to self-insured. This meant that Brook Mays Music Company would pay directly all claims that were covered under the plan. General American

Insurance Company received administrative services fees to administer and pay claims under an Administrative Services Agreement. Brook Mays Music Company additionally purchased indemnification coverage and consequently, General American received premiums to provide excess risk coverage providing specific indemnification for individual claims in excess of Twenty-Five Thousand and no/100 Dollars ($25,000.00) and aggregate indemnification to limit the overall claim liability of the plan.

There were several major differences between the prior year's plan and the one that was instituted on August 1, 1988. Among these differences were the following:

1. The individual calendar year deductible was increased from Two Hundred and no/100 Dollars ($200.00) to Three Hundred and no/100 Dollars ($300.00). The family deductible was increased from Six Hundred and no/100 Dollars ($600.00) to Nine Hundred and no/100 Dollars ($900.00);
2. The individual "stop loss" was increased from Four Thousand and no/100 Dollars ($4,000.00) in benefits to Ten Thousand and no/100 Dollars ($10,000.00) in covered expenses;
3. Treatment for AIDS (Acquired Immunity Deficiency Syndrome) and ARC (AIDS Related Complex) were limited to individual lifetime maximum of five Thousand and no/100 Dollars ($5,000.00);
4. All treatment for chemical dependency (drug abuse and alcoholism) was excluded from the plan;
5. A PPO (Preferred Provided

> Organization) network was added to the plan. Covered expenses in a PPO doctor's office were aid at one hundred percent (100%), subject to a Ten and no/100 Dollar ($10.00) encounter fee instead of eighty percent (80%), subject to the calendar year deductible. All other PPO doctor and hospital charges were paid at ninety percent (90%) instead of eighty percent (80%). Covered expenses for non-PPO providers remained unchanged.

The premium cost for medical coverage only per employee per month under this plan was Forty-Two and 58/100 Dollars ($42.58).

The number of employees covered by the Brook Mays welfare plan as of August 1, 1987, was one hundred fifty-two (152). The number of employees covered as of August 1, 1988, was one hundred forty-three (143). For the plan year beginning August 1, 1987, the welfare plan cost an average of One Hundred Three and 93/100 Dollars ($103.93) per employee per month. The plan cost for the year beginning August 1, 1988, was Ninety Two and 32/100 Dollars ($92.32) per employee per month. Had there been no change from the plan provided in the 1987 plan year to the 1988 plan year, the minimum medical premium per employee per month would have risen to Forty-Eight and 91/100 Dollars ($48.91) per month with a projected claims' liability of One Hundred Seventy Four and 07/100 Dollars ($174.07) per employee per month. Even changing plans did not allow employee contributions to remain status quo. Employee contributions were required to be increased by Two and 75/100 Dollars ($2.75) per payday for individual coverage and Seventeen and 50/100 Dollars ($17.50) per payday for family coverage.

The decisions which were made regarding these plans were difficult ones, but were done with the intent of preserving the financial integrity of the welfare plan while at

the same time allowing it to continue to provide health coverage for the employees of Brook Mays and H&H Music Companies."

Further affiant sayeth not.

/s/_____
WILLIAM C. EVERITT,SR.

SWORN TO and subscribed before me this the 8 day of January, 1990.

/s/_____
NOTARY PUBLIC
Carl B. Bolin
Typed Name of Notary

Notarial Seal

EXHIBIT "A"

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN McGANN
PLAINTIFF

vs. CIVIL ACTION
H & H MUSIC COMPANY NO. H-89-1995
BROOK MAYS MUSIC
COMPANY, AND GENERAL JURY DEMAND
AMERICAN LIFE
INSURANCE COMPANY,
DEFENDANTS

PLAINTIFF'S FIRST AMENDED COMPLAINT

JOHN MCGANN, Plaintiff, complains of H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, and GENERAL AMERICAN LIFE INSURANCE COMPANY, Defendants, as follows:

INTRODUCTION

1. Plaintiff brings this action for violation of his rights under §1140 of the Employee Retirement Income Security Act of 1974 (hereafter "ERISA"), 29 U.S.C. § 1001 et seq. Plaintiff alleges that Defendants have discriminated against him for exercising rights to which he is entitled under the provisions of an employee benefit plan, and for the purpose of interfering with the attainment of rights to which Plaintiff may become entitled under such plan, by wrongfully changing the employee benefits coverage provided to Plaintiff through his employment with Defendant H & H MUSIC COMPANY and provided through BROOK MAYS MUSIC COMPANY. Because of the continuing and irreparable nature of the resulting injury, Plaintiff seeks expedited preliminary injunctive relief from this Court restoring to him all prior benefits. Plaintiff also seeks, pursuant to §1140 of

ERISA, reasonable attorneys' fees and costs, all benefits due to him under the terms of his prior benefit plan, and permanent injunctive relief restraining Defendants from further discriminating against Plaintiff.

2. Plaintiff also invokes this Court's power of pendant jurisdiction and brings a claim pursuant to § 501(1) of the Texas Commission on Human Rights Act, V.A.T.S. art. 5221k (1987). Plaintiff alleges that Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY discriminated against him with regard to his employment-related benefits on account of his handicap, Acquired Immune Deficiency Syndrome (hereafter A.I.D.S"). Pursuant to the Texas Commission on Human Rights Act, Plaintiff seeks injunctive relief, cost and attorneys' fees, and compensatory damages.

3. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. Insurance Code, art. 21.21, § 4(7)(b), prohibiting "unfair discrimination" in the benefits or terms and conditions in any contract of health insurance or payment of benefits thereunder. Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY discriminated against him by refusing to insure or refusing to continue to insure Plaintiff due to his handicap. Pursuant to V.A.T.S. Insurance Code, art. 21.21, § 16, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of fact finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed the acts of discrimination complained of, the Court shall award, in addition, two times the amount of actual damages.

4. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. Insurance Code, art. 21.21-3, entitled "Discrimination Against Handicapped Prohibited," which prohibits an insurer from discriminating against a handicapped insured by

refusing to insure or refusing to continue to insure a handicapped individual. Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY unfairly discriminated against him by initiating a cessation of coverage. Pursuant to V.A.T.S. Insurance Code, art. 21.21, § 16. Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of fact finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed the acts of discrimination complained of, the Court shall award, in addition, two times the amount of actual damage.

5. Plaintiff also invokes the Court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. BUS. & COM. CODE § 17.41 et seq., the Texas Deceptive Trade Practices-Consumer Protection Act, which prohibits "false, misleading, or deceptive acts or practices in the conduct of any trade or commerce." Plaintiff alleges that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY, in providing its service as group insurer, committed false and deceptive acts by inducing certain acts or events so as to cause itself to change from insurer of the medical/hospitalization policy of Defendants H & H MUSIC COMPANY AND BROOK MAYS MUSIC COMPANY to merely becoming the administrator of such policy. Further, pursuant to V.A.T.S. BUS. & COM. CODE § 17.50, Plaintiff seeks injunctive relief, actual damages, court costs, and attorneys' fees. If the trier of facts finds that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY knowingly committed unconscionable acts, or acts in violation of V.A.T.S. Insurance Code art. 21.21, the Court shall award not more than three times the amount of actual damages in excess of $1,000.00.

6. Plaintiff also invokes the court's power of pendant jurisdiction and brings claim pursuant to V.A.T.S. BUS. & COM. CODE § 17.41 et seq., the Texas Deceptive Trade Practices-Consumer protection Act, which prohibits "false,

misleading, or deceptive acts or practices in the conduct of trade or commerce." Plaintiff alleges that Defendant employer, H & H MUSIC COMPANY, as fiduciary for the medical/hospitalization policy for employee JOHN McGANN, your Plaintiff, committed fraudulent acts by its intent to conceal from the Plaintiff, through a concerted effort with the other Defendants, that the medical/hospitalization group policy on which Plaintiff would rely to obtain his medically necessary treatments, would be modified to eliminate medical/hospitalization benefits. Plaintiff relied upon Defendant H & H MUSIC COMPANY to act as a proper fiduciary, and Plaintiff's reliance upon Defendant H & H MUSIC COMPANY has caused Plaintiff immense injury. Further, pursuant to V.A.T.S. BUS. & COM. CODE § 17.50, Plaintiff seeks injunctive relief, actual damages, court cost, and attorneys' fees. If the trier of fact finds that Defendant H & H MUSIC COMPANY knowingly committed unconscionable acts, or acts in violation of V.A.T.S. BUS. & COM. CODE § 17.50, the Court shall award not more than three (3) times the amount of actual damages in excess of $1,000.00.

7. Plaintiff also brings causes of action for breach of contract, and related state law claims against Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY, arising out of the breach of fiduciary duties by Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY.

JURISDICTION

8. This Court has jurisdiction of this action under § 1132(e) of ERISA, 29 U.S.C. § 1001 *et seq.*, and under its power of pendant jurisdiction to hear Plaintiff's state law claims. The state law claims and the federal law claims derive from a common nucleus of operative fact.

PARTIES

9. Plaintiff JOHN McGANN is a resident of Houston, Harris County, Texas, and a citizen of the United

States. He has been employed by Defendant H & H MUSIC COMPANY since 1982.

10. Defendant H & H MUSIC COMPANY is a Texas Corporation, doing business as a music store in Houston, Harris County, Texas. Its registered agent is Clyde W. Reynolds, who may be served with process at 1211 Caroline, Houston, Harris County, Texas 77002.

11. Defendant BROOK MAYS MUSIC COMPANY is a Texas corporation, doing business in Houston, Harris County, Texas. Its registered agent is William C. Everitt, who may be served with process at 644 West Mockingbird, Dallas, Dallas County, Texas 75247.

12. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY is a Missouri corporation, doing business in Texas. Its registered agent for service is Robert E. Jackson, who may be served with process at 1200 Summit Avenue, Suite 500, Fort Worth, Tarrant County, Texas 76102.

FACTS

13. At all relevant times, Defendant H & H MUSIC COMPANY was an employer engaged in an industry or activity affecting commerce within the meaning of 29 U.S.C. § 1002(5),(11), and (12) and § 2.01(5) of V.A.T.S. art. 5221k (1987).

14. At all material times, Plaintiff JOHN McGANN was an employee of Defendant H & H MUSIC COMPANY within the meaning of 29 U.S.C. § 1002(6) and § 2.01(4) of V.A.T.S. art. 5221k.

15. Defendant H & H MUSIC COMPANY'S employee benefits plan, including but not limited to its group medical/hospitalization benefits plan, is an employee benefit plan within the meaning of 29 U.S.C. § 1002(3) and 29 U.S.C. § 1140, and whose Plan Administrator is Defendant BROOK MAYS MUSIC COMPANY.

16. Plaintiff JOHN McGANN was and is a

participant in Defendant BROOK MAYS MUSIC COMPANY's employee benefits plan within the meaning of 29 U.S.C. § 1002(7) and 29 U.S.C. § 1140.

17. Plaintiff JOHN McGANN has been employed by Defendant H & H MUSIC COMPANY since 1982, and thereafter covered by Defendant BROOK MAYS MUSIC COMPANY's Group Medical Care Plan.

18. In December, 1987, Plaintiff JOHN McGANN was diagnosed as having A.I.D.S. This fact was well known by all defendants.

19. On August 3, 1988, Defendant BROOK MAYS MUSIC COMPANY announced that its Group Medical Care Plan covering Defendant H & H MUSIC COMPANY's employees, and wherein Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY had been insurer, was canceled effective August 1, 1988, and that the substituted group medical/hospit-alization policy would be self-insured, with Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY as administrator only. Benefits payable for A.I.D.S-related claims were modified from a lifetime maximum covered expense of $1,000,000.00 to only $5,000.00, and therefore potentially excluded $955,000.00 in insured expenses available to Plaintiff JOHN McGANN.

20. On October 12, 1988, Plaintiff JOHN McGANN filed a complaint with the Texas Commission on Human Rights, alleging that he was discriminated against by Defendant H & H MUSIC COMPANY on account of his handicap, A.I.D.S (TCHR Complaint No. 3890030). On or about April 10, 1989, he receive his "Notice of Right to File A Civil Action" from the Texas Commission on Human Rights.

21. Plaintiff believes that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY acted in conspiracy with Defendant H & H MUSIC COMPANY and Defendant BROOK MAYS MUSIC COMPANY to violate Plaintiff's rights under ERISA and to discriminate against

Plaintiff on account of his handicap, A.I.D.S. Prior to August 1, 1988, Plaintiff was fully insured for his handicapping condition of A.I.D.S for the maximum expense of $1,000,000.00. On August 1, 1988, the Defendants acted in concert in conspiring to discriminate against Plaintiff JOHN McGANN. Defendants schemed so that Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's obligations to Plaintiff JOHN McGANN would cease by termination of the General American policy and by imposition of an H & H Music Company/Brook Mays Music Company self-insured plan that limited the obligations of Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY to no more than $5,000.00 for claims related to Plaintiff's handicapped condition, but, again, whereby Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY remained administrator of the policy and no longer liable.

22. Defendants' wrongful actions towards Plaintiff have caused Plaintiff considerable mental suffering. Medical studies have consistently shown that increased anxiety levels, like that induced in Plaintiff by Defendants' actions, increase the likelihood or repeated infections and further worsen existing infections and medical problems of A.I.D.S patients.

FIRST CAUSE OF ACTION

Interference with Protected Rights Under ERISA

23. Defendants, by conspiring together to change Plaintiff's insurance coverage, acted for the purpose of interfering with Plaintiff's attainment of rights to which he was entitled or may have become entitled under the employee benefit plan of Defendant H & H MUSIC COMPANY or under ERISA, 29 U.S.C. § 1001 *et seq.* Defendants' actions thus constitute a violation of § 1140 of ERISA. As a result of Defendants' conspiratorial actions, Plaintiff has lost benefits of employment, suffered mental anguish, and been forced to employ attorneys in order to vindicate his rights and to obtain other appropriate equitable relief. In addition,

Plaintiff has been forced to accept an inferior medical/hospitalization insurance plan, which in essence is of little or no value, as it conveniently exempts those treatments that are necessary for maintenance of Plaintiff JOHN McGANN'S health.

SECOND CAUSE OF ACTION
Texas Commission on Human Rights Act

24. Defendant H & H MUSIC COMPANY discriminated against Plaintiff JOHN McGANN by changing his insurance coverage on account of his handicap, A.I.D.S., in violation of § 5.01(1) of the Texas Commission of Human Rights Act, V.A.T.S. art. 5221k (1987). As a result, Plaintiff has lost benefits of employment, suffered mental anguish, and has had to employ attorneys in order to vindicate his rights.

THIRD CAUSE OF ACTION
Violation of V.A.T.S. Insurance Code,
Art. 21.21

25. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY, by conspiring together with Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY to change Plaintiff's insurance coverage, sought to unfairly discriminate in the benefits or terms and conditions of their health insurance plan effective prior to August 1, 1988. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's actions constitute a violation of V.A.T.S. Insurance Code, art. 21.21, *et seq.* As a result of their acts, Plaintiff has lost benefits and has been forced to accept benefits that are virtually useless in assisting him in his immediate medical needs related to his handicapped condition.

FOURTH CAUSE OF ACTION
Violation of State Insurance Laws
Protecting Handicapped

26. Defendants, by conspiring together to change

Plaintiff's insurance coverage, sought unfairly to discriminate against Plaintiff, a handicapped person, by refusing to insure, or refusing to continue to insure, Plaintiff. As a result of these acts, Plaintiff has been damaged by the loss of benefits and has been forced to accept benefits that are virtually useless in assisting him in his immediate medical needs related to his handicapped condition pursuant to V.A.T.S. Insurance Code, art. 21.21-3.

FIFTH CAUSE OF ACTION
Deceptive Trade Practices by
Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY

27. Defendants, by conspiring together to change Plaintiff's insurance coverage, caused Plaintiff to be damaged by Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's false and deceptive acts by causing Plaintiff's existing medical policy to prematurely terminate. Defendant GENERAL AMERICAN LIFE INSURANCE COMPANY's acts were knowingly committed in violation of V.A.T.S. BUS. & COM. CODE § 17.41 *et seq.*; and, accordingly, Plaintiff has been damaged by the untimely loss of benefits and has been forced to accept benefits that are virtually useless in assisting him in his medical needs related to his handicapped condition.

SIXTH CAUSE OF ACTION
Deceptive Trade Practices by
Defendants H & H MUSIC COMPANY
and BROOK MAYS MUSIC COMPANY

28. By conspiring together to change Plaintiff's insurance coverage, Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY caused Plaintiff to be damaged by their false and deceptive acts, by their efforts to conceal information that they were purposely modifying their insurance policies to eliminate medical/hospitalization benefits that they knew were necessary to sustain Plaintiff. As a further direct and proximate result of this breach of

duty, Plaintiff will personally incur medical expenses that were previously insurable. As a further result of the false and deceptive acts of Defendants H & H MUSIC COMPANY and BROOK MAYS MUSIC COMPANY, Plaintiff has suffered and will continue in the future to suffer considerable and severe mental anguish and anxiety and increased physical suffering.

SEVENTH CAUSE OF ACTION
Breach of Duty Created by Agency

29. Defendant H & H MUSIC COMPANY acted as Plaintiff's agent for the purpose of doing generally what was needed to obtain and preserve insurance coverage for employees of H & H MUSIC COMPANY and owed to Plaintiff the duty owed by an agent to a principal. Defendant H & H MUSIC COMPANY breached this duty to Plaintiff by failing to notify Plaintiff, as obligated by such agency relationship, of the impending cessation of his needed medical/hospitalization benefits related to his known handicap. As a result of Defendant H & H MUSIC COMPANY's breach of duty, Plaintiff will personally incur medical expenses that were previously insurable. As a further result of Defendant H & H MUSIC COMPANY's breach of duty, Plaintiff has suffered and will continue in the future to suffer considerable and severe mental anguish and anxiety and increased physical suffering.

STATEMENT OF IRREPARABLE HARM

30. Plaintiff requests an expedited hearing on his request for preliminary injunctive relief, as Plaintiff will suffer irreparable injury unless this Court immediately orders Defendants to restore to Plaintiff his prior health insurance coverage, and restrains Defendants from further unlawful discrimination against Plaintiff. Defendants' unlawful actions are depriving Plaintiff of appropriate and necessary health insurance, and causing him to fear imminent financial and emotional helplessness. Such threatened injuries clearly outweigh any damage the requested injunction might cause to

Defendants' interests, and the interests of the public coincide with those of Plaintiff. Plaintiff has no adequate remedy at law due to the daily worsening of Plaintiff's financial and emotional states.

31. Plaintiff hereby demands a JURY on all issues triable by jury.

Wherefore, Plaintiff requests the following relief:

1. that, following an expedited hearing a preliminary injunction be issued to restore to Plaintiff his former insurance benefits; and that Plaintiff be granted a permanent injunction upon trial of this case;
2. that Plaintiff recover his compensatory damages, including the value of his lost insurance coverage, valued at NINE HUNDRED FIFTY-FIVE THOUSAND AND NO/100 ($955,000.00) DOLLARS and, additionally, such other actual damages as shall be proved at trial resulting from Defendants' unlawful conduct;
3. that Plaintiff, in addition to recovering actual damages, recover additional damages of TWO MILLION NINE HUNDRED EIGHTY-FIVE THOUSAND AND NO/100 ($2,985,000.00) DOLLARS, as pleaded, should the trier of fact find the requisite knowledge in the commission of Defendants' conspiratorial scheme;
4. that Plaintiff recover damages for his mental anguish resulting from Defendants' tortious and discriminatory conduct;
5. that Plaintiff recover punitive damages due to Defendants' malice and bad faith and as justified by the evidence at trial in a sum in excess of ONE MILLION AND NO/100 ($1,000,000.00) DOLLARS;

6. that Plaintiff be awarded prejudgment and post judgment interest at the maximum legal rate;
7. that Plaintiff recover reasonable attorneys' fees; and
8. that Plaintiff be awarded his costs of court and any other relief to which he proves himself entitled.

Respectfully submitted,

/s/ Helen Brattin
Helen Brattin
Southern District ID No. 5072
3212 Smith Street, No. 102
Houston, Texas 77006
(713) 650-3300

/s/Donald L. Skipwith
Donald L. Skipwith
Southern District ID No. 1841
3212 Smith Street, No. 102
Houston, Texas 77006
(713) 650-3300

ATTORNEYS FOR PLAINTIFF

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN McGANN
Plaintiff
vs.
H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY,

Civil Action
No. H-89-1995

VERIFICATION

STATE OF TEXAS §
§
COUNTY OF HARRIS §

BEFORE ME, the undersigned authority, on this day personally appeared JOHN McGANN, who, being by me duly sworn, made the following statements:

"My name is JOHN McGANN, and I am the Plaintiff in this cause. I am aware of the factual allegations of Plaintiff's First Amended Complaint, and all such factual allegations therein are true and correct."

s/s John McGann
John McGann

SWORN TO AND SUBSCRIBED BEFORE ME this 25 day of July, 1989.

/s/ Audrey L. Seawright
Notary Public in and for
the State of Texas
/s/ Audrey L. Seawright
Printed Name of Notary Public

My Commission expires:7/20/92

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

JOHN McGANN
Plaintiff

vs.

Civil Action
No. H-89-1995

H & H MUSIC COMPANY, BROOK MAYS MUSIC COMPANY, AND GENERAL AMERICAN LIFE INSURANCE COMPANY
Defendants

AFFIDAVIT OF JOHN McGANN

STATE OF TEXAS §
§
COUNTY OF HARRIS §

BEFORE ME, the undersigned authority, on this day personally appeared JOHN McGANN, who, being by me duly sworn, stated as follows:

"My name is JOHN McGANN. I am over the age of twenty-one (21) years and fully competent to make this affidavit. I am the plaintiff in the above-captioned lawsuit and am employed by Defendant H & H Music Company (hereafter 'H & H').

"In December 1987, I was hospitalized for pneumonia and diagnosed as having Acquired Immune Deficiency Syndrome ('AIDS').

"Although I was devastated by my diagnosis, I had every intention of fighting the virus by availing myself of the best of medical care. As an employee of H & H Music Company for six (6) years, I believed that I would be able to access payment of my needed medical care through my group medical/hospitalization insurance with H & H Music

Company. One of the first things I did after my diagnoses was to educate myself concerning the provisions and benefits of my insurance coverage. I had heard that there were insurance companies that discriminated against people with AIDS, but I never thought that this would be my case.

"My first claims for insurance benefits for this illness were submitted to the insurance carrier, Defendant General American Life Insurance Company (hereafter 'General American') in either Dcember 1987 or January 1988.

"Shortly after I returned to work at H & H, in early 1988, I told Charles Vick, the manager of my department at H & H, that I had AIDS. In March 1988, I participated in a meeting with Charles Vick and Clyde Reynolds, the president of H & H, where my illness (AIDS) was discussed. It was my naive belief that H & H would work to accommodate me in anyway they could, as I had always been a trusted and loyal employee.

"On or about August 3, 1988, the bottom fell out when I received a letter from H & H notifying me that my insurance coverage had changed effective August 1, 1988, and that the new insurance had a lifetime cap of Five Thousand ($5,000.00) Dollars for AIDS-related benefits. Clyde Reynolds told me that Mr. Everett, the owner of H & H, had made the decision to change insurance policies.

"On August 26, 1988, Robert Michels, an agent for General American, met with me and approximately eleven (11) H & H managers to discuss the change in insurance coverage. He told us that the change was the product of three (3) months of negotiations between General American and Mr. Everett.

"I asked Mr. Michels about the possibility of

my continuing to receive coverage under the old policy, and he told me that the policy had been terminated and was not an available option. He said there was no way I could purchase continuing coverage as an individual, either.

"I also attended a later meeting, on August 26, 1988, with just Mr. Michels and Clyde Reynolds. In this meeting Mr. Michels said that the new, selfinsured plan presented by H & H was subject to federal law and that if, at any time, federal law declared that discrimination against AIDS patients by reduction of benefits was illegal, my benefits would revert to those enjoyed by other H & H employees.

"To the best of my knowledge, I am the only employee of H & H who was affected by this change in coverage for AIDS-related illnesses; I know of no other employee of H & H with a previously covered condition who has been affected by the change.

"Until August 1, 1988, my insurance coverage through my employment at H & H provided me with a lifetime major medical maximum of One Million ($1,000,000.00) Dollars.

"I have exhausted the Five Thousand ($5,000.00) Dollars of coverage, and I am now compelled to pay for my medical care out of my diminished savings, and to weigh my proposed treatments against my own ability (or inability) to pay.

"I have no doubt that my medical condition and the prospects of my future utilization of my insurance for my medical condition was the prime motivator in their change in my coverage. Very simply, all that I now seek is restoration of my medical insurance coverage for a condition over which I had no choice in contracting, and which requires the protection of my insurance to combat.

"Further, Affiant sayeth not."

/s/ (illegible)

SWORN TO AND ACKNOWLEDGED BEFORE ME this 30th day of January, 1990.

/s/ Jackie K. Piper
Notary Public in and for
the State of Texas
/s/ Jackie K. Piper
Printed Name of Notary Public

My commission expires: 11/27/93

Plaintiff's Affidavit

H & H MUSIC COMPANY

General Offices:
11577 OLD KATY ROAD
HOUSTON, TEXAS 77043
(713 531-9222

Houston's Largest Full Line Music Company
"Since 1945"

July 28, 1988

Dear Valued Employees:

For many years we have provided a health insurance program for you and your dependents. Over the years, this plan has been responsible for heading off financial disaster which surely would have struck many families within the H & H Music Company family had it not been for this plan.

Over the last several years, the losses for the plan have mounted steadily. Last year the plan suffered financial disaster. For every dollar that was received in premium, almost $1.50 was spent in benefit payments. When you add to this the cost of paying the claims, administering the plan, and estimating the future impact of 20% inflation in medical cost, you can see that something drastic had to be done to save the plan. A time for tough decisions has come!

With these thoughts in mind, we were faced with either dropping the plan completely or redesigning the benefits so that we hopefully can get cost back under control; therefore, effective August 1, 1988, the following changes will be made to your medical plan:

1. Increase the calendar year deductible to $300.00.
2. Increase the individual stop-loss to $10,000 per calendar year. That is, the plan will pay 80% of covered expenses to $10,000 and then 100% of the remaining covered expenses for

the balance of the calendar year.

3. Limit treatment of AIDS to $5000.00. per individual lifetime.
4. Exclude all treatment for chemical dependency (drug abuse and alcoholism).
5. Add the Sanus/Passport Preferred Provider Network and Utilization Review to the program. This arrangement will essentially allow you to choose physicians and hospitals which have negotiated with us to provide medical care on a reduced precontract fee basis. There will be financial incentives for you to use the providers on a preoccurrence basis. It will be a freedom of choice plan. Because of the complexities involved and the education required, there will be manager briefings for this program by the end of August or first of September. Then the managers will brief the employees on the benefits of this arrangement.
6. Increase employee contributions by $2.75 per pay day for individual coverage and $17.50 per day for family coverage.

While the decisions we had to make in order to save the plan were tough, we think that these changes will save the financial integrity of the plan and continue to allow it to provide financial security to the employees and their families of H & H Music Company.

Sincerely yours,
/s/_____
William C. Everitt

SCHEDULE PAGE

The amounts shown below are the maximum amounts payable as subsequently explained:

Employee Only Insurance Coverage:

	Benefit Amounts
Life Insurance	(See most recent
Accidental Death and	certification form
Dismemberment Insurance	for amounts)

Modification of Insurance Schedule

The amount of Life and Accidental Death and Dismemberment Insurance of an employee less than age 65 shall be reduced to 65% of the otherwise applicable amount on his 65% birthday.

In no event shall an employee's Accidental Death and Dismemberment Insurance be more than $20,000.00 on or after his 70th birthday.

The Accidental Death and Dismemberment Insurance may not be converted to an individual policy.

EMPLOYEE AND DEPENDENT INSURANCE COVERAGE:

MEDICAL CARE INSURANCE;

Major Medical Expense:

Major Medical Maximum $1,000,000.00

Deductible Amount -- an amount of covered expenses to which the deductible requirement applies equal to the

Individual Deductible Amount of.....200.00

or the Family Deductible Amount of.....600.00

No part of any covered expenses for which benefits are paid or payable under the Insured Portion may be used to satisfy the Family Deductible Amount.

The family deductible must be satisfied by the employee and members of his family insured as dependents.

The Benefits Maximum and the Deductible Amount shown above are subject to adjustment in the case of a person who has received benefits or incurred changes subject to the deductible, or both, under the Schedule previously in effect.

Deductible Accumulation Period -- full calendar year (or end of next calendar year when expenses are "carried over" from one calendar year to the next, as explained in the Deductible Requirement provision on a Major Medical benefits description page).

Additional Deductibles:
A) For Inpatient Hospital Confinement:
MCB-81-SCH-(5353) -1-

Contributions to Plan:
You pay a portion of the cost to insure yourself and your dependents.

Termination of Amendment of Plan:
The Plan Sponsor may terminate or amend the Plan at any time or terminate any benefit under the Plan at any time. If premiums are not paid to the Insurance Company the benefits issued by the Insurance Company shall terminate at the end of the Grace Period.

The Insurance Company may terminate the benefits provided under the Group Policy by giving 31 days notice to the Plan Sponsor.

If less than 100% of those employees who do not have to contribute for dependent insurance under the Group Policy or less than 75% of those employees who do have to contribute for such dependent insurance are insured for such insurance, the Insurance Company may cancel the dependent insurance by giving notice in writing to the Plan Sponsor at least 31 days prior to the date insurance will end.

Cancellation of the policy or any of its provisions may be without the consent of the Plan Sponsor or any person claiming rights or benefits under the plan. If the policy cancels or any provision ends, it shall not affect any claim which begins before the date the policy or such provision ends, subject to the terms and conditions of the policy.

MAJOR MEDICAL BENEFITS

SCHEDULE

Important Notice
Your Medical coverage includes one or more features to help control medical care costs. Some features will affect the amount of benefits payable for your medical care. See the Cost Containment section of this plan for a further explanation.

Employee and Dependent Coverage	Amounts Applicable To You or a Dependent

Medical Care

Lifetime Maximum For
All Covered Expenses.....1,000,000

Lifetime Maximum for covered expenses incurred for:

1. all treatment of nervous and mental conditions.....$25,000
2. AIDS (Acquired Immune Deficiency Syndrome) and ARC (AIDS Related Complex.....$ 5,000

Deductible Amount - an amount of covered expenses to which the Deductible Requirement applies equal to:

the Individual Deductible
Amount of.....$ 300
or the Family Unit Deductible
Amount of.....$ 900

The Family Unit Deductible must be satisfied by you and your family unit member's covered as dependents.

No part of any covered expenses for which benefits are paid or payable by the plan may be used to satisfy the Family Unit Deductible Amount.

<u>The following is Applicable When Services of a Participating Provider Are Utilized:</u>

Deductible

Services	The Plan Will Pay	Applies
1. Outpatient Diagnostic X-ray and Laboratory Service Charges incurred due to injury or illness (includes pre-admission testing)	100%	No
2. Outpatient Surgery and Anesthesia Service Charges	100%	No
3. Outpatient Hospital Charges for Medical Care, Services and supplies in connection with surgical procedures or injuries	100%	No